FROM POLICY TO SERVICE: A QUALITY VISION FOR BEHAVIORAL HEALTH

Using the Quality Chasm and New Freedom Commission Reports as a Framework for Change

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Introduction

In 2001 the American College of Mental Health Administration (ACMHA) convened its annual Summit and examined the relevance for behavioral health care of the Institute of Medicine's Crossing the Quality Chasm report. Over 90 leaders in the behavioral health care field agreed that the report provided a compelling argument for the need to reform the American health care system in general, and more specifically behavioral healthcare. There was consensus that the IOM framework could serve as an effective tool for strategic redirection of the field.

This monograph builds upon the work of the ACMHA Summit with additional input from a work group convened by SAMHSA and ACMHA in May 2003. That group provided additional review of the Quality Chasm report, The President's New Freedom Commission and other initiatives. There are important and complimentary links between them that together create a roadmap for systems change.

This report provides an overview and summary of these efforts and is intended for wide distribution in the field from policy makers to managers as well as direct care staff and consumers. It offers a summary of strategic initiatives for policy reform, service improvement and quality behavioral healthcare. Several case studies are also included as illustrations of projects and initiatives that respond to the challenges from the IOM and the President's Commission.

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Crossing the Quality Chasm and The President's New Freedom Commission A Framework For Change

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A Framework For Change

Overview

There is an emerging but clear consensus, shared amongst a wide array of stakeholders that our current health care delivery systems don't work and are in need of fundamental reform. Concerns about the quality and performance of both general and behavioral healthcare delivery systems has been a central focus of debate about US health policy for many years. While the two systems share much in common, the problems of the behavioral healthcare system have been complicated, in part, by the fragmentation resulting from the historical "carve-out" of behavioral healthcare from the larger health system. This has occurred in both publicly funded and commercially insured care systems. It is time to consider a plan for change.

Recent reports over that past several years, including a series of critical studies published by the Institute of Medicine, (2000, 2001, 2002, 2003) and the President's New Freedom Commission (2003) and the Surgeon General's Report on Mental Health (1999), amongst others, have attempted to provide both incisive analysis as well as calls for action in order to support the pressing need for reform and transformation of the American healthcare system.

…these documents are limited by their failure to fully integrate the issues shared by both behavioral and general health.

In a compilation of reports referred to as the Quality Chasm Series, the Institute of Medicine (IOM) not only identified problems but perhaps more importantly provided a new conceptual framework for defining and operationalizing quality in healthcare. The work includes a review of medical errors (*To Err is Human,* 2000) followed by an examination of quality (*Crossing the Quality Chasm: A New Health System for the 21st Century,* 2001). The series also includes an examination of health disparities (*Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,* 2002) and the role of the federal government as a purchaser of healthcare for over 100 million people (*Leadership by Example: Coordinating Government Roles in Improving Health Care Quality,* 2002). This report also examines the role of performance measurement in the purchase of quality health care services. The final report in the series, *Priority Areas for National Action: Transforming Health Care Quality* (2003), is a review of priority conditions that show the greatest promise for quality improvement.

While individually and together these IOM reports provide a blueprint for the redesign and transformation of American health systems, there is little focus on the role of behavioral healthcare in the overall system of care. Although behavioral health conditions and related concerns were included in the priority areas, limited attention

beyond this has been paid to the unique issues and challenges facing the mental health and addictive disorders field.

In 2002, President Bush identified three obstacles that prevent those with mental illness from getting the quality care they deserve. These include, 1) the stigma that surrounds mental illnesses, 2) unequal limitations and financial requirements that are placed upon mental health benefits in privately insured health care, and 3) a fragmented mental health delivery system (2003). Based upon these concerns, the President's New Freedom Commission was established to review the state of behavioral healthcare in America and make specific recommendations for the future. The final report of the Commission identified 6 goals and recommendations. They envisioned a world in which:

1. Americans understand that mental health is essential to overall health.
2. Mental health care is consumer and family driven.
3. Disparities in mental health services are eliminated.
4. Early mental health screening, assessment, and referral to services are common practice.
5. Excellent mental health care is delivered and research is accelerated.
6. Technology is used to access mental health care and information.

Taken together, the work of the Institute of Medicine and the President's New Freedom Commission address the key concerns for healthcare in general and specifically for behavioral health. The reports are strikingly consistent in their critique of current systems of care and the need for fundamental reform to achieve quality and better serve those in need. At the same time, both of these documents are limited by their failure to fully integrate the issues shared by both behavioral and general health.

Examining these two reports in detail, including an analysis of the overlap between them, provides a framework to create a model for behavioral healthcare system redesign as well as a strategy for implementation and action.

Crossing the Quality Chasm: A New Health System for the 21st Century

The Quality Chasm report indicates that the American health care system is broken and in need of system redesign, if Americans are to receive the quality care and improved outcomes that they deserve. The IOM is clear in its assertion that incremental change--simply trying harder with existing models--will not work and reform can only be achieved through fundamental change or transformation. To that end the IOM identifies *six aims* for the redesign of American health systems. These core values stipulate that healthcare should be:

- Safe
- Person-centered[1]
- Efficient
- Effective
- Timely
- Equitable

[1] For behavioral healthcare there has been a significant debate about the use of language and the implications of the terms *patient, consumer, or client*. For this report, the term person-centered has been substituted for the original IOM term patient-centered.

Taken together, these six aims are effectively a redefinition of quality in healthcare that resonates with the concerns and perspectives of many stakeholders. While building on the earlier work of Donabedian (2003) and his model of structure, process and outcome, this framework speaks immediately and directly to the experience and frequent frustrations of those who seek healthcare services.

In order to realize the quality aims, the IOM report suggests that there is set of *ten rules* that should guide and direct the delivery of care. These include the idea that:

1. Care is based upon continuous healing relationships.
2. Customization is based on patient needs and values.
3. The patient is the source of control.
4. Shared knowledge and the free flow of information is essential.
5. Decision-making is evidence based.
6. Safety is a system priority.
7. There is a need for transparency in all aspects of healthcare delivery.
8. Needs are anticipated.
9. The reduction of waste is ongoing.
10. Cooperation among clinicians is a priority.

In an effort to lay out a strategy for system reform, the IOM made a series of recommendations including a call for the identification of a set of priority areas as the focus of quality improvement initiatives. An initial set of 20 areas has been identified and includes two specific behavioral health conditions: depression as well as severe and persistent mental illness with a focus in the public sector (2003).

Despite the specificity of the framework and the clarity of the recommendations, translation into action remains a challenge. In what was described as a "users manual" Berwick (2002) laid out a strategy by conceptualizing four "levels" within healthcare systems that individually and together should be the focus of change. These include:

	LEVEL	*IMPACT*
A	Experience of Patients and Communities	*Recipients of care*
B	Micro-systems of Care	*Direct care providers*
C	Healthcare Organizations	*Larger health systems*
D	Public Environment	*Policy, financing, and regulations*

Berwick argues that any discussion about changing the process or outcome of care must be aligned at the proper level within the health system. This framework truly has the potential to be a users manual by providing a tool for analyzing the relationships between the various stakeholders, quality aims and system rules in any reform effort. Using the metaphor of a compass, Berwick identifies the experience of individuals, families and communities as being "true north" and central to any effort at quality reform. We must always orient our work to this ordinal point; it must always guide the way in systems change and improvement.

Lastly, the Quality Chasm report identifies four activities or opportunities for immediate focus that are essential for the redesign of health systems. These include:

- Applying evidence to the delivery of health care services
- Using information technology
- Aligning payment policies with quality improvement
- Preparing the workforce to follow the rules and achieve the aims

These opportunities, coupled with Berwick's levels, provide the outline for developing an agenda for action.

The President's New Freedom Commission Report

The President's New Freedom Commission was established in April 2002 and asked to study the existing mental health system and make recommendations that would enable adults with serious mental illness and children with serious emotional disturbances to better live, work, learn, and participate in their communities. The final report, *Achieving the Promise: Transforming Mental Health Care in America* (2003) detailed the Commissioner's findings and is predicated on the notion that our complex mental health delivery system is in need of fundamental transformation. In addition to the six goals noted above, a number of specific objectives were identified as part of the transformation process. Together these 6 goals and the corresponding 19 objectives summarize the work of the Commission. This outlines a comprehensive agenda for the redesign of behavioral health services and systems of care. At the same time, however, they fall short in many respects of actually describing how that change should occur.

A summary of the New Freedom Commission's recommended goals and objectives can be found in Table 1.

A New Health System for Behavioral Healthcare

The works of the Institute of Medicine and the President's New Freedom Commission are simultaneously critical indictments of American health care systems and the most optimistic models for the reform of these services. Yet, there remains a need to continually examine the integration of both behavioral and general health care services. Taken together, these two models provide a framework for the development of a comprehensive roadmap for change.

An overview of the relationship between the six aims outlined in the Quality Chasm report and the corresponding recommendations from the President's Commission can be found in Table 2. Not only does this analysis illustrate the consistency between the reports but also highlights the relevancy of each set of findings, but the six aims also provide a useful tool for evaluating the relationship between the IOM's definition of quality and the Commission's Goals.

Table 1

GOALS	OBJECTIVES
1. Americans understand that mental health is essential to overall health.	1.1 Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention. 1.2 Address mental health with the same urgency as physical health.
2. Mental health is consumer and family driven.	2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance. 2.2 Involve consumers and families fully in orienting the mental health system toward recovery. 2.3 Align relevant Federal Programs to improve access and accountability for mental health services. 2.4 Create a comprehensive State mental health plan. 2.5 Protect and enhance the rights of people with mental illness.
3. Disparities in mental health services are eliminated.	3.1 Improve access to quality care that is culturally competent. 3.2 Improve access to quality care in rural and geographically remote areas.
4. Early Mental Health Screening, Assessment, and Referral to Services are Common Practice.	4.1 Promote the mental health of young children. 4.2 Improve and expand school mental health programs. 4.3 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies. 4.4 Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.
5. Excellent Mental Health Care is Delivered and Research is Accelerated.	5.1 Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illness. 5.2 Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation. 5.3 Improve and expand the workforce providing evidence-based mental health services and supports. 5.4 Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.
6. Technology is used to access mental health care and information.	6.1 Use health technology and telehealth to improve access and coordination of mental health care especially for Americans in remote areas or in underserved populations. 6.2 Develop and implement integrated electronic health record and personal health information systems.

Table 2

IOM Aims	*President's Commissions Recommendations*
Safe	1.1 Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention. 2.5 Protect and enhance the rights of people with mental illness.
Person-Centered	2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance. 2.2 Involve consumers and families fully in orienting the mental health system toward recovery.
Effective	4.2 Improve and expand school mental health programs. 4.3 Screen for co-occurring mental and substance abuse disorders and link with integrated treatment strategies. 4.4 Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports. 5.2 Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation. 5.3 Improve and expand the workforce providing evidence-based mental health services and supports. 5.4 Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.
Efficient	2.3 Align relevant Federal Programs to improve access and accountability for mental health services. 2.4 Create a comprehensive State mental health plan. 6.2 Develop and implement integrated electronic health record and personal health information systems.
Equitable	3.1 Improve access to quality care that is culturally competent. 3.2 Improve access to quality care in rural and geographically remote areas. 4.1 Promote the mental health of young children. 6.1 Use health technology and telehealth to improve access and coordination of mental health care especially for Americans in remote areas or in underserved populations.
Timely	1.2 Address mental Health with the same urgency as physical health. 5.1 Accelerate research to promote recovery and resilience and ultimately to cure and prevent mental illness.

It is important to understand what is meant by each of the six aims. A detailed explanation, sensitive to the concerns of mental health system stakeholders, is provided for each aim.

Safe

Services are provided in an emotionally and physically safe, compassionate, trusting and caring treatment/working environment for all clients, family members and staff.

The IOM aim of safety is addressed within two of the larger goals of the President's Commission. These include:

1) The understanding that mental health is essential to overall health.
2) That mental healthcare is consumer and family driven.

Embedded within these goals are recommendations that include efforts to reduce the stigma of those seeking care as well as a plan for the prevention of suicide. Equally important is the effort to protect and enhance the rights of people with mental illness.

Safety must be a priority across the entire spectrum of the health system. There are significant issues at each of the levels of care and for both publicly and privately funded systems of care. These include access to crisis services, reduction of involuntary treatment, the elimination of seclusion and restraint, and the community integration of people with mental illness into safe neighborhoods with ready access to transportation and adequate resources for healthy nutrition and life-styles.

The concept of safety is fundamental to mental health. The destructive impact of stigma is prevalent and the potential for injury to both those with mental illness and those who care for them is significant. Systems must be established that protect the rights of persons with mental illness as well as support access and intervention that promotes the well being of these individuals and their families.

Person-Centered

A highly individualized comprehensive approach to assessment and services is used to understand each individual's and family's history, strengths, needs and vision of their own recovery including attention to the issues of culture, spirituality, trauma and other factors. Service plans and outcomes are built upon respect for the unique preferences, strengths and dignity of each person.

The goal of consumer and family driven care is central to the President's Commission report. It is also the essence of the IOM aim of care that is "person-centered". Two specific recommendations from the President's Commission further elaborate on and address this issue. This includes the call for:

1) An individualized plan of care for adults and children with mental health needs.
2) The involvement of both recipients of care and their families in an orientation towards recovery.

Other recommendations in this Commission goal are addressed by other Quality Chasm aims including Safety and Efficiency.

Whether one is more comfortable with the term patient, consumer, client, person, etc., there is no avoiding the fact that recipients of care and their families and communities must be central to the care process. This concept is well articulated in the Quality Chasm rules for the role of "patients" and families in the care process and their participation in decision-making. Berwick has described this role, Level A, as the "True North" of health care (Berwick 2001). A clear commitment to individuals, families and communities must be the roadmap that guides all health services.

Effective

Up-to-date evidence-based services are provided in response to and respectful of individual choice and preference.

The aim of effectiveness care is linked to two of the Commission's goals. These include:

1) The common practice of early mental health screening, assessment and referral for services.
2) Along with the expectation that excellent care is delivered and research is accelerated.

Both of these goals foster effective care.

In the recommendations of the Commission there are a number of strategies for implementation. These include the improvement and expansion of mental health programs in school systems. For screening, it is important to recognize and screen for co-occurring substance abuse disorders and the screening for mental disorders in primary care across the life span. Both of these approaches require integrated treatment and support systems.

A second area of effective treatment that is recommended in the Commission report includes the use of evidence-based care and the preparation of the workforce. This includes the development of a behavioral health workforce capable of consistently providing evidence-based mental health services. Four specific areas are also targeted for increased study due to an underdeveloped knowledge base. These include needing to better understand:

- Best approaches to the problems of mental health disparities
- The long-term effects of medications
- The role of trauma in mental health and illness
- The specific challenges in providing acute care

The importance of public-private partnerships is also stressed.

Historically, the role of evidence-based care in behavioral health has been limited. There has been broad debate about the measurement of outcomes and the disparities that exist across systems. This Quality Chasm aim and the Commission's recommendations support care that is based in effective systems of care and promote early detection and intervention.

Efficient

Human and physical resources are managed in ways that minimize waste and optimize access to appropriate treatment.

The IOM aim of efficiency states that health systems should avoid waste, including equipment, supplies, ideas, and energy. There are two goals in the Commission report that support this aim:

1) Mental health care should be consumer and family driven.
2) Technology is used to access mental health care and information.

The recommendations of the Commission support the alignment of the full range of federal programs to promote increased accountability and improved access for mental health services. In addition, there should be a comprehensive state mental health plan created to coordinate services. The Commission report also proposes the development of an integrated electronic health record for all personal health information. These recommendations support the reduction of waste in both the general and behavioral health systems. The use of electronic health records and other information technologies are also central to the Quality Chasm reports.

Efficient systems of care are crucial for behavioral healthcare. Because there are differences between both public and private care, as well as primary and specialty care, the potential for waste and inefficiency are significant. In order to promote change, efficiency must be an objective at both the level of payers of care as well as providers of care. The potential role for technology that supports improved efficiency also needs to be considered.

Equity

Access and quality of care do not vary because of client or family characteristics such as: race, ethnicity, age, gender, religion, sexual orientation, disability, diagnosis, geographic location, socioeconomic status or legal status.

The Quality Chasm aim of equity is articulated in three of the Commission's goals. These include:

1) The elimination of disparities in mental health services, early mental health screening.
2) Assessment and referral services are common practice.

3) The use of technology to access mental health care and information.

Within these recommendations, the concepts of access to culturally competent and geographically accessible care are prominent. Technology is also championed as a resource to improve access and coordination for underserved populations. The importance of promoting the mental health of young children is also articulated.

Disparities are common across all levels of healthcare; behavioral healthcare is no exception. These disparities are seen in both the public and private systems of care. The role of culture, language and geography are central components. Funding for services are inconsistent across states and there is a lack of comprehensive services for all that need them.

Timely

Goal-directed services are promptly provided in order to restore and sustain clients and families integration in the community.

The aim of timeliness is the focus of two of the Commission's goals. These include the notions that:

1) Americans understand that mental health is essential to overall health.
2) Excellent mental health care is delivered and research is accelerated.

The recommendations that support this aim and goals include the need to address mental health with the same urgency as physical health and the acceleration of research to promote recovery and resilience in order to ultimately prevent and cure mental illness.

Despite many years of effort to improve systems, Access to mental health services remains an ongoing problem. There is clearly a disparity between general healthcare and behavioral healthcare. This often results in delays in services and misdiagnosis of mental illnesses. The lack of coordination with other co-occurring substance abuse disorders also results in delays in access to care that are both harmful and unnecessary.

A Plan of Action

A number of recent reports have presented a compelling critique and analysis of the state of behavioral healthcare and the compelling need for substantial changes in the field. These include the Surgeon Generals Report on Mental Health (1999), the Institute of Medicine's reports on the quality of healthcare in America (2000, 2001, 2002, and 2003), and the recent President's Commission report on Transforming Mental Health Care in America (2003). Taken together, all of the recent reports support an emerging clarity among stakeholders about a set of priorities and a common agenda for change (Adams and Daniels, 2002). Together these influences can be examined and a plan of action developed.

The Quality Chasm report identifies four areas for immediate action in the redesign of health systems. These include:

- Applying evidence to the delivery of health care services
- The use of information technology
- Aligning payment policies with quality improvement
- Preparing the workforce

Each of these areas provides its own unique and significant opportunity for change in behavioral health care systems. A systematic review of each of these strategies serves as a template for a plan of action to implement both the Quality Chasm and President's Commission reports.

The behavioral health field is committed to finding solutions and a process of continuous quality improvement. There are a number of innovative programs that have used the Quality Chasm framework to foster and strategically map change. An open call to the field, led by a joint sponsored initiative between Center for Mental Health Services and the American College of Mental Health Administration, has produced a number of illustrations. These are included as case studies as an appendix to this report.

Applying Evidence to the Delivery of Healthcare

Scientific knowledge is rapidly changing and ever expanding. The application of new knowledge in clinical practice is an ongoing challenge for all clinical specialties. The Institute of Medicine has estimated that it takes an average of seventeen years for new knowledge that is generated by controlled clinical trials to be incorporated into practice (IOM, 2001). Even when this occurs, the incorporation into clinical practice is uneven and inconsistent. This problem in behavioral healthcare is even more problematic because of the multiple professional disciplines and their inconsistent licensing and continuing education requirements (Daniels and Walters, 2002).

The Quality Chasm's Six Aims specifically address the concept of effective care. Services that are evidence based are fundamental to all of the aims and rules that are outlined in the report. The President's Commission articulates that excellent care is predicated on the advancement of evidence-based care and supported by public and private partnerships that guide implementation. It is clear that not only must evidence based care be a part of any redesign process, but it is inextricably linked to all other areas of the system and change processes.

The redesign of the behavioral healthcare delivery system requires changes in both the structure and process. This requires the involvement of recipients of care, the providers and organizations of care systems, and the social and political environment that surrounds health care. Each of the four areas identified by the Institute of Medicine are necessarily intertwined in the structure and process of care. Evidence based care is contingent upon

the technology that supports it, the workforce that delivers care, and the systems that reimburse for services.

The Use of Information Technology

Information technology potentially provides a large lever to support and promote the reform of health care delivery systems. Key to this is changing the current state of recording and accessing clinical information. Typically kept in a paper form, the clinical record is limited by the system of organization, its legibility, and the lack of potential for integration between providers. It is also a one-way repository of professional input, generally void of meaningful contribution by the recipients of care. The IOM aims focus on providing efficient, timely, and patient-centered care. Improvements in all of these areas will be greatly impacted by improvements and greater access to technology for expedient communication of detailed information that incorporates the recipients of care in the accumulation of information and materials. One of the six goals in the President's Commission includes several objectives for the use of technology in mental health reform. This includes better deployment of technology resources for access and care coordination, as well as, for the integration of personal health information.

A number of important issues confound the use of information technology in behavioral healthcare. Recent guidelines for patient privacy and security of protected health information have been developed (e.g. HIPAA). The use of electronic information storage also challenges the essential commitment to confidentiality and anonymity in the care process. There will likely be increased debate on this issue, as well as solutions - as more behavioral health records are integrated into the general health record.

Information technology is exploding in the operation of healthcare systems. It continues to be important for behavioral healthcare to explore the potential for these new resources and technologies. Mindful of the unique attributes of behavioral health, it will be necessary to identify opportunities for innovation and advancement in information resources, improved care processes, and integrated health records.

Aligning Payment Policies with Quality Improvement

Both the Quality Chasm Report and the President's Commission have made the case that the healthcare delivery system is broken and in need of structural reform. A key component of any system redesign must address the role of financing care and quality incentives. The allocation and adequacy of resources for behavioral care is an ongoing issue. In the private sector, the allocation of insurance premium dollars for behavioral healthcare has been consistently declining over the past several years (Hay Group Report, 1999). In the public sector, funds for mental health are allocated differently across states. The President's Commission has described the existing system as complex and inconsistent and a challenge to the principle of equity. The Quality Chasm report calls for systems of care that are both efficient and equitable. The need to better understand the essential resource needs along with implementing improved mechanisms for accountability is essential.

Quality has also been an inconsistent feature of mental health services. Accreditation programs have provided some standardization, but a clear and consistent vision of quality remains absent. Different performance measurement systems have has been developed for the public and private systems of care. In addition, core performance measurement sets have been developed at the different levels of care throughout mental health systems of care.

The IOM has proposed a standard set of performance measures be used in the government's purchasing of health services (Leadership by Example, 2002). An initiative jointly funded by SAMHSA's Center for Mental Health Services and the Center for Substance Abuse Treatment, *The Forum on Performance Indicators*, is an effort to develop common performance measurement across both fields. While progress has been slow, there is an emerging consensus on the use of common measures. Clearly a standard set of performance measures would benefit the field and support this change factor as proposed by the IOM.

Preparing the Workforce

A clear crisis exists in the current behavioral health workforce. The Quality Chasm report has identified this as a central factor in the process of systems reform. The President's Commission also champions the improvement and expansion of the workforce and their ability to provide evidence based care.

Together, these reports suggest that there is a serious problem in the development and deployment of the professional workforce. While behavioral health care has changed dramatically over the past fifteen years, the educational systems that prepare the workforce have failed to keep pace (Hoge, 2002). In addition, while the voice of the behavioral health consumer has grown in policy discussion, and their role has also proliferated in direct care, their participation in the training and education process has been limited at best. Payment and training incentives have lagged behind this expanding role (Morris and Stuart, 2002).

The Annapolis Coalition for Workforce Development (www.annapoliscoalition.org) is a collaborative project of the American College of Mental Health Administration and the Academic Behavioral Health Consortium. This initiative has examined the serious crisis that exists in the development of the behavioral health workforce and identified the need to create a coalition of educators, providers, policy leaders and other stakeholders' to address this problem. The resistance to change is great, but the need for reform is pressing. In order for system reform in behavioral healthcare to succeed, there will need to be significant changes in the workforce—both within the field and across all health care delivery.

Conclusions

The President's Commission on mental health has clearly made the case that the current care system is complex, and contains fragmentation and gaps in the care of children, adults with serious mental illness, and the elderly. There is a persistent stigma against those with mental illness that results in a lack of employment and persistent disability. In addition, there is not a clear national priority for mental health and suicide prevention.

The Institute of Medicine has developed a series of reports that articulate the prevalence of medical errors, the inconsistent quality of care, health disparities, and the lack of a national agenda to purchase care through the use of performance indicators. The Quality Chasm series clearly demonstrates that current healthcare systems are broken. Perhaps more importantly, they make the compelling case that simply a greater effort alone will not fix them. Change will require a fundamental shift in how health systems are designed and function.

While the Institute of Medicine has not focused specifically on behavioral health, the President's Commission has. However, these reports are complimentary and together they offer a framework for the reform of the behavioral health field. The President's Commission articulates a comprehensive set of Goals and Recommendations for the reform of the mental health system. The Quality Chasm report offers a clear set of Aims or common values, and a set of Ten Rules for how the redesigned health systems should operate. A review of the Commission's Goals and Recommendations with the Six Aims of the Quality Chasm report provides a call to action for the reform of behavioral healthcare. This can only be achieved through the core directions articulated by the Commission report and the core principles from the IOM.

Four areas for the reform of health systems have also been advanced by the Quality Chasm report. These areas can be considered a call to action for the behavioral health field. These include applying evidence to the delivery of health care services, the use of information technology, aligning payment policies with quality improvement, and preparing the workforce. These four areas serve as the framework for the development of action strategies for the field.

Strategies and methods for achieving reform are as important as change itself. Perhaps nothing is more important in the end than maintaining focus on the experience of recipients of care and their families. This commitment must set the compass and serve as "True North" on the roadmap for change (Berwick 2001). Behavioral health has made significant strides in the inclusion of consumers in the policy and delivery process. Ongoing reforms of the system must incorporate culturally competent care that is based in evidence, utilize all of the advancements in technology, and be supported by ongoing quality improvement and reimbursement systems that support new systems of care.

Case Studies

There are a number of innovative programs that are currently utilizing the work of the Institute of Medicine in their strategic improvement of behavioral health care services and policy. The case studies included in this report are some examples of some of this work and illustrate the ongoing opportunities to respond to the challenges outlined by the IOM and the President's Commission.

Case 1: CALIFORNIA'S MENTAL HEALTH QUALITY IMPROVEMENT FRAMEWORK

Following the American College of Mental Health Administration Summit in March of 2001, several members of the California Department of Mental Health's Statewide Quality Improvement Council formed a workgroup to further explore the relevance and utility of the Quality Chasm framework for the state's quality initiatives. The workgroup included broad stakeholder representation with active participation by consumers, family members and providers.

The group found that the basic framework needed to be revised and redefined so that it better reflected the values principles and language of the mental health community. For example, "patient centered" was renamed person-centered and described as follows:
A highly individualized comprehensive approach to understanding each individual's and family's history, strengths, needs and vision of their own recovery including attention to the issues of culture, spirituality, trauma, and other factors that impact service plans and outcomes which are built upon respect for the dignity of each person.

A similar approach was used for the rules. For example the IOM rule calling for evidence-based decision-making was recast as: Decision-making is guided by the values, preferences, needs and desires of the person/family as well as current best evidence.
In addition several overarching principles were added to address concerns about the need to be equitable, culturally competent and recovery oriented in all endeavors. The group also considered how Berwick's analysis of levels within a system of care (Berwick, 2002) identified opportunities and strategies for change by consumers and families, providers, the county and state mental health authorities and the larger State and Federal governments.

As a result of this work, there is now increasing interest in the use of this framework as an organization principle for all quality improvement and strategic planning activities in the State's mental health system. Examples include: One of the State Hospitals is using the framework's six aims to plan and implement an initiative to reduce and eliminate seclusion and restraint based on the recognition that this goal can only be reached through broad systems-based quality transformation.

The State's Mental Health Planning Council is considering using the six aims to examine how financing strategies might be used to improve quality of care. Having completed this developmental phase, it is increasingly clear to all stakeholders that having a unifying and coherent framework can enhance the state's efforts at quality improvement. Several specific objectives and next steps include: Using this common framework, help to coordinate efforts and decrease fragmentation in quality improvement efforts amongst all stakeholders.

Providing a consistent framework for organizing current measurement and reporting efforts and provide direction for future data collection and measurement. Providing tools for prioritizing statewide, regional and local quality improvement efforts. Using the framework to promote quality improvement activities by providing clearly defined aims and rules in addition to current emphasis on quality assurance and compliance.

Case 2: PURSUING PERFECT DEPRESSION CARE: ELIMINATING SUICIDE

Henry Ford Health System Behavioral Health Services

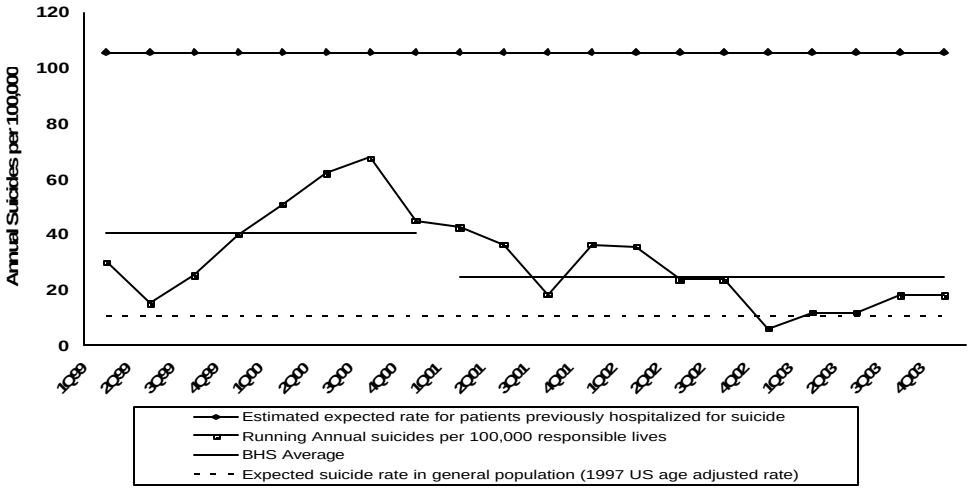
In response to the IOM's *Chasm Report*, the Robert Wood Johnson Foundation launched its "Pursuing Perfection Initiative", in 2001 and funded 12 demonstration projects designed to show that rapid, radical improvement in health care using the IOM framework for quality was possible. Henry Ford Medical Group's Behavioral Health Services was selected to work on improving the care of persons with depression *and* in so doing transform the mental health care processes within the Henry Ford Health System.

The project team used the six aims from the *Chasm Report* both to define "perfect" depression care (i.e., such care should be safe, effective, patient-centered, timely, efficient, and equitable), and as a strategic framework within which to develop and implement such systems of care. After mapping their current core processes of care, the issue of suicide was identified as a high-leverage opportunity to improve depression care and the elimination of suicide among their patients was selected as the project goal. This audacious goal served to galvanize the team and sent an important message that this was the beginning of a journey to transform behavioral health care.

The project re-engineered Henry Ford's behavioral healthcare delivery system and implemented the Planned (Chronic) Care Model of care as a framework for providing perfect care. The team reviewed the scientific literature and developed a "Suicide Prevention" clinical pathway (effective care), which included elements of self-management support (patient-centered care) as well as important linkages to community resources. The system was redesigned to ensure that patients had ready access to care (timely, efficient) and that each encounter with a clinician included an evidenced-based assessment of immediate risk for suicide, followed by the appropriate level of intervention.

The results to date have been encouraging. In the two years prior to the launch of the Perfect Depression Care Initiative (there were approximately 42 suicides per 100,000 covered lives as compared to a rate of 12 per 100,000 for the general population, and over 100 per 100,00 for a psychiatric population of mixed inpatients and outpatients. Since launching the initiative in January 2001, and since then the annual rate has fallen to 18 per 100,000, a decrease of approximately 57%.

These results indicate that rapid, dramatic improvement in depression care is possible, and that the *Chasm Report* framework provides a useful roadmap for conceptualizing and implementing such improvements.



Case 3: NEW YORK STATE OFFICE OF MENTAL HEALTH'S WINDS OF CHANGE CAMPAIGN

New York's State Office of Mental Health (OMH) has worked to implement some of the IOM's principles for improving the quality of health care in America with a focus on three of the six aims: effectiveness, efficiency and person-centeredness. Prior to the publication of the Crossing the Quality Chasm report, the State's public mental health authority had begun a multi-year initiative to introduce the use of evidence-based practices (EBPs) into routine mental health service delivery settings. Since the State's Office of Mental Health (OMH) annually oversees services to more than 600,000 adults and children, this campaign has significant potential to transform public mental health systems throughout the nation.

Planning for the campaign began initially in late 1999 when senior managers responded to the seminal findings of the Surgeon General's report on Mental Illness. The report, which concluded that the majority of Americans were not being exposed to known and effective mental health interventions, became a "call to arms" throughout the nation and in OMH efforts were expanded from initial interest in developing teams for Assertive Community Treatment (ACT) to a wider list of interventions having significant research histories of effectiveness. The list also included promising practices and several service interventions for children.

With the publication of "Crossing the Quality Chasm", the campaign was significantly expanded to promote the adoption of evidence based practices as but one component of a sweeping agenda to improve the quality of mental health care by shifting culture and practice toward data driven, performance based decision-making. This shift in emphasis has required the OMH to develop new management tools to support continuous quality improvement, including different tools for inspecting licensed programs and adoption of a performance measurement model, starting with utilization and outcomes for inpatient care. This model is being developed with the intent of using performance outcomes to help allocate funding, thereby measurably improving efficiency at returning value to the State for its investments.

In 2002, OMH also sponsored a series of four "dialogues" with state and national experts, policy makers and consumer and family member stakeholders concerning the challenges of implementing evidence-based practices within the IOM's quality improvement construct. The recommendations of these experts are now part of the agency's formal five-year comprehensive plan for services.

Case 4: A MANAGED CARE STRATEGY FOR EARLY IDENTIFICATION OF SUICIDE RISK

PacifiCare Behavioral Health

PacifiCare Behavioral Health (PBH) is a specialty health managed care organization providing management of mental health and chemical dependency benefits nationwide. In February 1999, PBH implemented **AL**gorithms for **E**arly **R**eporting and **T**reatment (ALERT ®). One of ALERT's important functions is to improve identification and management of suicidal ideation. This function is consistent with the Institute of Medicine's aims of providing treatment that is:

***Safe* –** avoiding injury to consumers caused by clinical mistakes

Consumer-centered – providing care that respects and responds to individual consumer preferences, needs and values

Timely – reducing waits and harmful delays in care

This system assesses clinical risk and outcomes by inviting consumers to complete a 30-item questionnaire at regular intervals during treatment. ALERT utilizes consumer self-report questionnaires and the PAR (Provider Assessment Report). These self-report questionnaires inquire about symptoms and problems that are common among consumers of outpatient behavioral health services. Higher scores indicate greater severity or distress, and improvement is measured by the reduction in scores over time. PBH network practitioners are trained to administer these assessment measures at set intervals during the treatment episode. However, it has been noted that clinicians appear to significantly under estimate the severity of both suicidal ideation and substance abuse problems.

Prior to 2001, the clinician assessment of suicidal ideation was in agreement with the consumer's report less than 50% of the time, suggesting an unacceptably high rate of assessment errors. Through a system of provider notification, the percent concordance increased to 63% in 2001. This improvement has held constant in 2002. Clinician assessment of suicidal ideation is more likely to be concordant with the consumer report for child and adolescent consumers than for adults.

The consumer's report of suicidal ideation has been found to be the single best indicator of future hospitalization. It stands to reason that making the clinician more aware of the intensity of the suicidal ideation facilitates more proactive discussion of risk with the consumer. Thereby, managing risk and ensuring an adequate intensity of services for the consumer is addressed more effectively. The empirical findings of ALERT constitute good news for consumers and providers of behavioral health services. A continued goal is to increase the concordance rates for ratings of suicidal ideation.

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Biography

Allen Daniels, Ed.D., LISW, is the Chief Executive Officer for Alliance Behavioral Care; a regional managed behavioral healthcare organization. He is also the Executive Director for University Psychiatric Services, a multidisciplinary behavioral group practice. Both of these organizations are affiliated with the Department of Psychiatry at The University Of Cincinnati College Of Medicine where he is a Professor of Clinical Psychiatry. Dr. Daniels is a graduate of the University Of Chicago School Of Social Services Administration, And The University Of Cincinnati. Dr. Daniels has extensively published in the area of managed care, group practice operations, quality improvement and clinical outcomes, and academic healthcare. He has consulted both nationally and internationally on these subjects. He is also actively involved in a number of projects related to behavioral healthcare and the Institute Of Medicine's Quality Chasm Series.

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